DISABLED ACCESSIBLE VAN TRANSPORTATION
APPLICATION

NAME: _____

ADDRESS: _____ ZIP: _____

APARTMENT# _____ DATE OF BIRTH: _____

PHONE NUMBER _____ NEAREST CROSS STREET: _____

DISABLED PARKING PERMIT# _____ ISSUED BY: _____

EMERGENCY CONTACT: _____

PHONE: _____ RELATIONSHIP TO YOU: _____

DO YOU USE:
_____ CANE
_____ WALKER
_____ WHEELCHAIR
_____ CRUTCHES
_____ OTHER

PHYSICAL LIMITATIONS: _____

WILL AN AIDE ACCOMPANY YOU? ____ YES ____ NO

NEED FOR ACCESSIBLE VAN:
_____ MEDICAL
_____ RECREATIONAL
_____ GROCERY SHOPPING
_____ OTHER

I certify that the statements and information contained are true. I further acknowledge that I have read and understand the conditions of the application.

Date: _____ SIGNATURE: _____